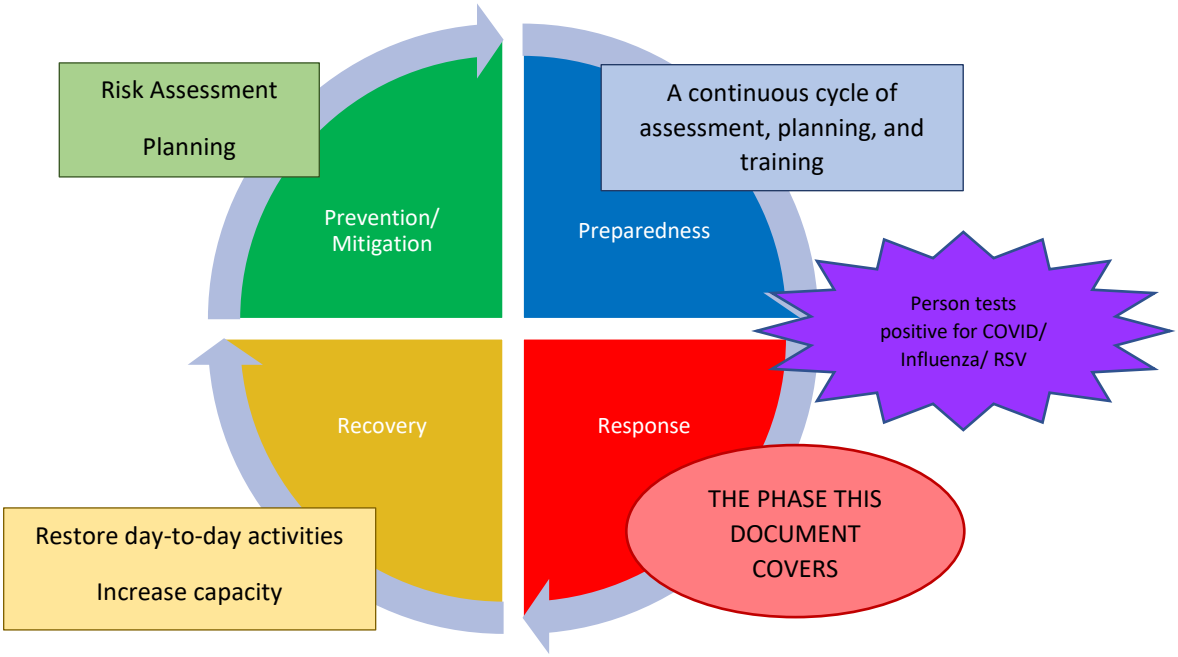
Respiratory Illness Outbreak Response Tool

For Use in **Adult Foster Care and Homes for the Aged**

This document is intended to assist Adult Foster Care (AFC) and Homes for the Aged (HFA) facilities with taking steps to address an outbreak of respiratory illness at their facility. The graphic below represents one way to manage an outbreak by separating the steps into Response, Recovery, Prevention/Mitigation, and Preparedness. This document addresses the "Response" phase. The Response phase is initiated with confirmation (or in some cases, suspicion) of a single case of a transmissible respiratory disease, including COVID-19, Influenza, or RSV, within the facility. This Response Tool can be used as part of a facility's Infectious Disease Plan and could be utilized by staff and leadership to initiate prevention and control strategies should the need arise.



Adapted from FEMA "The Four Phases of Emergency Management"

Guidance in this document is up to date as of September 20th, 2023.

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*****While this document is organized in a step-by-step process for ease of understanding, these steps should be done as concurrently as possible. *****

Guidance in this document is up to date as of September 20th, 2023.

Part One: Steps

Step 1: Resident Placement

AFC/HFA with Isolation Unit

Resident(s) Tests Positive for respiratory illness!

- Place person in a single-person room. The door should be kept closed. Ideally the person should have a bathroom that *only* he or she uses.
- Consider having space in your facility set aside for the purpose of separating symptomatic persons from asymptomatic persons, particularly in times when seasonal respiratory illness is circulating in the community.
- When private rooms are not available, create space within the room to encourage social distancing.
- Provide facemasks to persons with signs and symptoms of respiratory infection. Encourage all persons entering the facility to put on facemasks when respiratory illness has been detected in the facility and or in the community.
- Provide reminders and encourage cough etiquette (i.e., coughing in your sleeve, use a tissue).
- Facilitate testing to identify or rule out a communicable cause for the symptoms (See Step 3: Outbreak Testing).

- *Assisted Living, Group Homes, And Other Residential Care Settings (Excluding Nursing Homes) Should Follow CDC Guidance for Recommended Infection Prevention and Control (IPC) Practices When Caring for a Patient with Suspected or Confirmed COVID-19 Infection.*

Infection Control: Severe acute respiratory syndrome coronavirus 2 (COVID-19) | CDC

CDC Prevention Strategies for Seasonal Influenza in Healthcare Settings

CDC Clinical Signs and Symptoms of Influenza

APIC Infection Prevention and Control for Shelters

- Provided as informational as guidance in this document may be more applicable for smaller, more home-like, residential settings or settings where clients are cared for or congregate in large communal areas.

Expansion

Need more beds to accommodate the number of residents with symptoms/ positive test results?

- When additional beds are needed, ideally, utilize the rooms nearest to the existing isolation rooms.
- There may be instances that call for keeping a confirmed-positive resident in his/her current room (shelter-in-place model), whether for some or all residents positive for a respiratory infection.
    - Residents who have tested positive for an infectious respiratory illness should not room with residents who are not confirmed positives.
    - If cohorting, only residents with the *same respiratory pathogen* should be housed in the same room. Presence of other communicable disease should also be taken into consideration during the cohorting process.
    - For respiratory pathogens that can be transmitted via the airborne route, the door should remain closed, if safe to do so.
    - Strict adherence to hand hygiene and personal protective equipment (PPE) use (as appropriate for the specific infection) is necessary and should be regularly audited when a shelter in place model is being utilized, due to the increased risk for transmission when cohorting is not utilized.
    - Consider limiting the number of staff who enter the isolation rooms. If staffing allows, decrease the potential for transmission by assigning staff to care for only residents on transmission-based precautions (designated staff). If staffing does not allow for the use of designated staff, ensure all direct care staff are competent in their infection prevention education and training.
    - A ‘standard precautions’ to ‘transmission-based precautions’ (TBP) workflow should be followed as much as possible (e.g., when taking vital signs or passing medications) to limit the potential for cross-contamination

from isolation rooms to non-isolation rooms. Clean-to-dirty workflow is the process of caring for residents who do not have an infectious disease first, then working with those who do, so an infectious disease is not carried from the infectious person to a healthy resident.
• The MDHHS IPRAT Unit is available to support facilities with infection prevention guidance and best practices and may be contacted at MDHHS-IPRAT@michigan.gov.
Infection Control: Severe acute respiratory syndrome coronavirus 2 (COVID-19) | CDC

Step 2: Transmission-Based Precautions (TBP)

Organism-Specific TBP

Standard Precautions should be followed in addition to any of the below Transmission-Based Precautions.
COVID-19: **Droplet-Airborne Precautions**
• Ideally, the person should be placed in a negative pressure room.   ○ When a negative-pressure room is not available, consider the use of temporary portable solutions to create a negative pressure environment (such as exhaust fans). Work with an Infection Preventionist, if available, or Clinical Director and Building Maintenance/ HVAC contractor to ensure safe implementation. • Single room when available. • Consider alternative location for placement, if available, as indicated by facility Communicable Disease Management Plan and based on type of infection. • Prioritize persons with excessive cough for single-room placement. • Cohort persons who are infected with the same pathogen and type (I.e., COVID with COVID).
• Staff should wear a fit-tested NIOSH-approved N95 respirator, eye protection, gown, and gloves when entering the room. • The door should remain closed, if safe to do so. • Windows in the room should remain closed unless a fan is in use to create a negative pressure room. This avoids inadvertent flow of air from the isolation room to the hallway/ common area. • Limit movement outside of the room by resident to medically necessary purposes. • Resident should wear a surgical mask if they are leaving the room and when staff is in the room.
Standard Precautions should be followed in addition to any of the below Transmission-Based Precautions.
Influenza: **Droplet Precautions**

• Single room when available.
• Prioritize persons who have excessive cough and sputum production for single-room placement.
• Cohort persons who are infected with the same pathogen and type (i.e., Influenza A with Influenza A).
• If it becomes necessary to place persons who require Droplet Precautions in a room with a person who does not have the same infection:
  ○ Avoid placing them with persons who are at higher risk for adverse outcomes (e.g., immune compromised).
  ○ Ensure persons are physically separated (i.e., > 3 feet apart) and employ physical barriers (such as a privacy curtain) to reduce opportunities for close contact.

• Staff should wear a surgical mask when entering the room. • Limit movement outside of the room by resident to medically necessary purposes. • Resident should wear a surgical mask if they are leaving the room.
Standard Precautions should be followed in addition to any of the below Transmission-Based Precautions.
RSV: **Contact Precautions**
• A single-patient room is preferred. • When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options. • In multi-patient rooms, ≥3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the residents.

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• Provide ample opportunity for residents to perform hand hygiene.
• Staff should don a gown and gloves when entering the room. Surgical mask should be donned per Standard Precautions. • Limit movement outside of the room by resident to medically necessary purposes. • Resident should wear a surgical mask if they are leaving the room.
General Concepts
• Consider broader mask use (universal source control) during an outbreak of respiratory illness in the facility, when COVID-19 or other respiratory viruses are circulating in the community, during respiratory virus season (October – April), or for staff who work in areas of the facility where there is an increased likelihood of encountering a person with undiagnosed illness. • Even when masking is not required by the facility, individuals should continue using a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

• If performing an aerosol-generating procedure (AGP) during an outbreak, ensure appropriate precautions are taken including, but not limited to:
  ○ Keep door closed during an AGP.
  ○ Staff wear N95 respirator and other PPE per facility policy.
  ○ Limit the number of staff in the room to only those essential for the procedure.
  ○ Use AGP signage to alert others that an AGP is in process.
• See Appendix 1 for AGP resources and Appendix 8 for AGP signage.

Precautions | Appendix A | Isolation Precautions | Guidelines Library | Infection Control | CDC • A searchable list of pathogens and the associated transmission-based precautions. Ventilation in Buildings, ASHE Temporary Negative Pressure Rooms

General Precautions

Preparation of the isolation room or area – these should be performed to the best of the facility's ability.
• Ensure that appropriate handwashing facilities and hand-hygiene supplies are available.
• Stock the sink area with suitable supplies for handwashing, and with alcohol-based hand rub, near the point of care and the room door.
• Post transmission-based precautions signage on the door indicating that the space is an isolation area. (See Appendix 8 for printable signage.)
• Stock the PPE supply and linen outside the isolation room or area (e.g., in the change room). Setup a cart outside the door to hold PPE. A checklist may be useful to ensure that all equipment is available (see sample checklist below).
• Place appropriate waste bags in a bin. If possible, use a touch-free bin. Ensure that waste bins are available inside and outside the residents' rooms to allow for appropriate donning/doffing procedure. Ensure that used (i.e., dirty) bins remain inside the isolation rooms.
• Disinfect equipment upon exit from the Transmission Based Precautions (TBP) room.
• Dedicate non-critical resident-care equipment (e.g., stethoscope, thermometer, blood pressure cuff and sphygmomanometer) to the resident, if possible. Thoroughly clean and disinfect resident-care equipment that is required for use by other residents before use.
• Keep adequate equipment required for cleaning or disinfection inside the isolation room or area, and ensure scrupulous daily cleaning of the isolation room or area.
• Place a puncture-proof container for sharps disposal inside the isolation room or area.
• Remove all non-essential furniture and ensure that the remaining furniture is easy to clean and does not conceal or retain dirt or moisture within or around it.

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• Keep the residents' personal belongings to a minimum. Keep water pitchers and cups, tissue wipes, and all items necessary for attending to personal hygiene, within the resident's reach.
• Ensure that visitors consult the health-care worker in charge (who is also responsible for keeping a visitor record) before being allowed into the isolation areas. Keep a roster of all staff working in the isolation areas, for possible outbreak investigation and contact tracing.
• Set up a telephone or other method of communication in the isolation room or area to enable residents, family members or visitors to communicate with health-care workers. This may reduce the number of times the workers need to don PPE to enter the room or area.

Supply Checklist for Isolation Room or Area *(see Appendix 9 for printable version)*

Equipment	**Stock Present**
On PPE Cart:	
Eye Protection (face shield or goggles)	
Gloves	
Particulate respirators (N95 or equivalent)	
Medical (surgical or procedure) masks	
Gowns	
Available in or near the room/ area:	
Alcohol-based hand rub	
Plain soap (liquid, if possible, for washing hands in clean water)	
Clean single-use towels (e.g., paper towels)	
Sharps containers	
Appropriate detergent for environmental cleaning and disinfectant for disinfection of surfaces, instruments or equipment (Should be on the EPA List N)	
Large plastic bags in waste bins	
Appropriate biohazard bags	
Linen bags	

*Adapted from World Health Organization: Infection Prevention and Control of Epidemic- and Pandemic-Prone Acute Respiratory Infections in Health Care

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Step 3: Outbreak Testing

General Testing Recommendations

General: *If your facility does not have the capacity to test for* COVID, Influenza, *and/ or* RSV, *consider collaborating with your local health department for testing of staff or residents.*

- Anyone with symptoms of COVID-19, regardless of the severity of symptoms or vaccination status, should receive a viral test as soon as possible.
- Consider testing for both COVID-19 and Influenza at times when both are known to be circulating in the community as a person can be infected with both viruses simultaneously.

COVID-19

- Asymptomatic residents and staff with close contact with someone with COVID-19 infection should be tested on day 6 following their exposure.
- Persons who have been exposed to COVID-19 should wear a mask or respirator for 10 days following their exposure when around others, even when initial test results are negative.
- Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from COVID-19 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- If a resident or staff is unable to be tested following exposure or for symptoms, consider implementing other mitigation strategies such as empiric transmission-based precautions (quarantine), mask wearing, and/ or work restrictions for 10 days following exposure or the start of symptoms.

Influenza and Respiratory Syncytial Virus (RSV):

- Testing for influenza may be warranted if:
  - A person who has symptoms consistent with a viral respiratory infection test negative for COVID-19.
  - If there is more than one person in the facility with onset of symptoms compatible with influenza or RSV infection within 2-3 days of each other.
  - If the results of the testing will change the outbreak control strategy in the facility.
  - If the facility includes person at high-risk for complications from Influenza or RSV (e.g., persons > 65, pregnant women, persons with chronic lung or heart disease, or immunocompromised persons).
- The local health department may direct the facility to test certain individuals based on current community indicators or incidence in the facility.

CDC Interpreting COVID Antigen Testing Algorithm

What to Do If You Were Exposed to COVID-19 | CDC

CDC Information for Clinicians on Influenza Virus Testing

Guide for considering influenza testing when influenza viruses are circulating in the community

CDC Influenza virus testing in investigational outbreaks in institutional or other closed settings

COVID-19: Contact Tracing Testing

Perform contact tracing to identify any STAFF or residents who may have had close contact with the individual with *COVID-19* infection:

- All staff and residents who have been identified as close contacts to someone who has tested positive for COVID-19, regardless of vaccination status, should be tested as described in the testing section above.

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- **If testing of close contacts reveals additional staff or residents with COVID-19 infection**, contact tracing should be continued to identify residents or staff with close contact to the newly identified individual(s) with COVID-19 infection.
  - A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
  - If the outbreak investigation is broadened to either a facility-wide or unit-based approach, follow recommendations below for broad-based outbreak testing.

COVID-19: Broad-Based Testing:

A broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
• Ideally, perform testing for all facility residents and staff (or on the affected unit/s), regardless of vaccination status. • At a minimum, asymptomatic residents and staff with close contact with someone with COVID-19 infection should be tested on day 6 following exposure. (Anyone with symptoms should be tested immediately.) • If the exposure date is unknown, test all residents and staff upon confirmation of a new case of COVID-19 in the facility.   ○ Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from COVID-19 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
• In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of empiric use of Transmission-Based Precautions for residents and work restriction of staff with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
• If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated.
• If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach.
• If antigen testing is used, negative test should be repeated for a total of 3 tests for the most reliable results. After the first test, test again in 48 hours, and if negative, again 48 hours later.
• Collaborate with local public health authorities to determine the frequency and duration of testing.

Testing for Influenza and RSV:

In settings with persons at high-risk of complications from *Influenza* or *RSV*, a single case of suspected *Influenza* or *RSV* is sufficient for triggering testing and consideration of prompt implementation of infection prevention and control measures, including active surveillance for new illness cases.
• With a single case of confirmed influenza in the facility, increase monitoring of all residents for symptoms of respiratory illness.
• Test any client with acute onset of respiratory symptoms with or without fever.
• Collaborate with medical provider/s to determine if antiviral treatment is appropriate for individuals with symptoms and/ or those with a known exposure (post-exposure prophylaxis). **Antiviral treatment is most effective if administered within 48 hours of onset of symptoms.** Treatment can be started prior to receiving test results.
• Interpretation of test results should consider the clinical presentation (symptoms) of the person being tested, the method of testing, and the circumstances under which the test was performed (symptomatic and/ or as part of an

outbreak investigation). (See Algorithm to assist in the interpretation of influenza testing results and clinical decision-making during periods when influenza viruses are circulating in the community | CDC)
Clinical Practice Guidelines by the Infectious Diseases Society of America: 2018 Update on Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza | Clinical Infectious Diseases | Oxford Academic (oup.com) Past Michigan Flu Focus Surveillance Reports

Step 4: Notification - LHD

The presence or suspected presence of all reportable diseases, infections, and conditions are required to be reported to the appropriate local health department. The "appropriate local health department" means: • The local health department that has jurisdiction where an individual who has a disease or condition that is required to be reported resides. • The local health department of the county in which your service facility is located. In some counties, the local health department where your facility is located desires to have all reports routed through them, regardless of where the infected individual resides. Please contact your local health department for information specific to reporting for your agency.
MDHHS Communicable Disease Reporting in Michigan MDHHS Local Health Department Contact Information/ Maps Directory | Michigan Association for Local Public Health (malph.org) 2023 MDHHS Reportable Diseases in Michigan - By Pathogen 2023 MDHHS Reportable Diseases in Michigan - By Condition Infection Prevention Resource and Assessment Team (IPRAT) (michigan.gov) Contact IPRAT for assistance with the outbreak at mdhhs-iprat@michigan.gov.

Step 5: Quarantine/Isolation Duration

Quarantine

Staff in Assisted Living, Group Homes, And Other Residential Care Settings (Excluding Nursing Homes) Should Follow CDC Guidance for Recommended Infection Prevention and Control (IPC) Practices When Caring for a Patient with Suspected or Confirmed *COVID-19* Infection.
• If staff in a residential care setting are providing in-person services for a resident with COVID-19 infection, they should be familiar with recommended IPC practices to protect themselves and others from potential exposures including the hand hygiene, personal protective equipment and cleaning and disinfection practices outlined in this guidance.
• The IPC recommendations described below also apply to residents with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic residents who have met the criteria for quarantine based on close contact with someone with COVID-19 infection. However, these residents should NOT be cohorted with residents with confirmed COVID-19 infection unless they are confirmed to have COVID-19 infection through testing.

Guidance in this document is up to date as of September 20th, 2023.

***** Note that the recommended quarantine period listed below for congregate settings is longer than the duration recommended for the general public because of the risk of widespread transmission in dense housing environments and the high prevalence of underlying medical conditions associated with severe COVID-19.***

- AFC/ HFAs should consider their facility's unique risk factors (facility structural and operational characteristics, ability of residents to wear a mask, testing access, underlying health issues of the residents, etc.) of their facility when deciding between using community/ public strategies vs. congregate setting guidance.
- Consultation with local public health authorities is recommended, particularly when ongoing transmission is occurring.

Additional Information for Community Congregate Living Settings (e.g., Group Homes, Assisted Living) | CDC

Duration of Quarantine for Symptomatic Residents Being Evaluated for *COVID-19* Infection

- The decision to discontinue quarantine by excluding the diagnosis of current COVID-19 infection for a resident with symptoms of COVID-19 can be made based upon having negative results from at least one viral test.
  - If using NAAT (molecular/ PCR), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for COVID-19 infection exists, consider maintaining TBP and confirming with a second negative NAAT.
  - If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen ("rapid"/ "point-of-care") test taken 48 hours after the first negative test.
- If a resident suspected of having COVID-19 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgement and suspicion of COVID-19 infection determine whether to continue or discontinue quarantine.

Duration of Quarantine for Asymptomatic Residents following Close Contact with Someone with *COVID-19* Infection

- In general, asymptomatic residents do not require quarantine while being evaluated for COVID-19 following close contact with someone with COVID-19 infection. These residents should still wear source control and those who have not recovered from COVID-19 infection in the prior 30 days should be tested as described in the testing section.

- Examples of when quarantine following close contact may be considered include:
  - Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure
  - Resident is moderately to severely immunocompromised
  - Resident is residing on a unit with others who are moderately to severely immunocompromised
  - Resident is residing on a unit experiencing ongoing COVID-19 transmission that is not controlled with initial interventions

- For facilities choosing to implement quarantine after a person is exposed to someone with COVID-19, a 10-day quarantine period provides the greatest protection from potential COVID-19 transmission to other residents and staff.
  - Residents can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
  - If viral testing is not performed, residents can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC

- See "Setting-specific considerations" for community prevention strategies.

Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities | CDC

- A resource for high-risk congregate living settings.

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Isolation

Duration of Transmission-Based Precautions for Residents with *COVID-19* Infection

- The following are criteria to determine when Transmission-Based Precautions could be discontinued for residents with COVID-19 infection and are influenced by severity of symptoms and presence of immunocompromising conditions. Residents should be monitored and re-evaluated for symptom recurrence or worsening (either through self-monitoring or by caregiver). If symptoms recur (e.g., rebound), these residents should be placed back into transmission-based precautions until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for COVID-19 infection unless an alternative diagnosis is identified.

*****As mentioned above, the recommended duration of isolation for congregate settings is longer than the duration recommended for the general public because of the risk of widespread transmission in dense housing environments and the high prevalence of underlying medical conditions associated with severe COVID-19.***

*****Consultation with local public health authorities is recommended if facilities are considering an isolation period shorter than 10 days.***

- Residents who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:
  - At least 10 days have passed since the date of their first positive viral test due to the dense housing environment.
  - Consult with local public health authorities if considering an isolation period shorter than 10 days.

- Residents with mild to moderate illness who are *not* moderately to severely immunocompromised:
  - At least 10 days have passed *since symptoms first appeared* **and**
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- Consult with local public health authorities if considering an isolation period shorter than 10 days.

- Residents with severe to critical illness and who are *not* moderately to severely immunocompromised:
  - At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
  - Symptoms (e.g., cough, shortness of breath) have improved.
  - The test-based strategy as described for moderately to severely immunocompromised residents can be used to inform the duration of isolation.

- In general, residents should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation (at least 10 days). Then they should revert to usual facility source control policies for residents.

Infection Control: Severe acute respiratory syndrome coronavirus 2 (COVID-19) | CDC

Additional Information for Community Congregate Living Settings (e.g., Group Homes, Assisted Living) | CDC

Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities | CDC
A resource for high-risk congregate living settings.

Duration of Transmission-Based Precautions for residents with suspected or confirmed *Respiratory Syncytial Virus (RSV)*

- People infected with RSV are usually contagious for 3 to 8 days and may become contagious a day or two before they start showing signs of illness. However, some people with weakened immune systems, can continue to spread the virus even after they stop showing symptoms, for as long as 4 weeks.
- In immunocompromised residents, extend the duration of Contact Precautions due to prolonged shedding. Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions is uncertain.

Transmission of RSV (Respiratory Syncytial Virus) | CDC

Guidance in this document is up to date as of September 20th, 2023.

Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) (cdc.gov)
Duration of Transmission-Based Precautions for residents with suspected or confirmed *Influenza*
• *Droplet precautions* should be implemented for residents with suspected or confirmed influenza for *7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer*, while a resident is in a healthcare facility. In some cases, facilities may choose to apply droplet precautions for longer periods based on clinical judgment, such as in the case of young children or severely immunocompromised residents, who may shed influenza virus for longer periods of time.
Prevention Strategies for Seasonal Influenza in Healthcare Settings | CDC For more information about making decisions on resident placement for droplet precautions: Isolation Precautions | Guidelines Library | Infection Control | CDC

Part Two: Appendices

Appendix 1: Aerosol Generating Procedures (AGP)

Infection Control: Severe acute respiratory syndrome coronavirus 2 (COVID-19) | CDC • Refer to bottom of the page for "Infection Control FAQ" section and see question, "Which procedures are considered aerosol generating procedures in healthcare settings?"
Air Exchange Table / CDC
Interactive Ventilation Tool | CDC

Appendix 2: Hand Hygiene

Healthcare Providers | Hand Hygiene | CDC
Hand Hygiene Audit Tool / CDC
Clean Hands Count Campaign | Hand Hygiene | CDC

Appendix 3: PPE Donning/Doffing

Sequence for Donning Personal Protective Equipment (PPE) (cdc.gov)
Personal Protective Equipment Use Tracking Tools | NIOSH | CDC

Appendix 4: Cleaning and Disinfection & Clean to Dirty Workflow

Best Practices for Environmental Cleaning in Healthcare Facilities: in Resource Limited Settings / CDC
Environmental Services / CDC
Environmental Cleaning Procedures / CDC
Cleaning and Disinfection Strategies for Noncritical Surfaces and Equipment / CDC
Environmental Cleaning Supplies and Equipment / CDC
Strategies to Mitigate Cross Contamination of Non-critical Medical Devices / APIC
Non-critical is Critical Infographic / APIC

Guidance in this document is up to date as of September 20th, 2023.

Appendix 5: COVID-19 Treatment

MDHHS Healthcare Provider COVID-19 Outpatient Therapy Toolkit
Coronavirus - COVID-19 Therapeutics Information Page (michigan.gov)

Appendix 6: Crisis Staffing

Nurse Aide Training Programs Map
Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC

Appendix 7: General Educational Resources

MI_BCHS_AFC Division - YouTube
Project Firstline (michigan.gov)
Project Firstline Infection Control Training | CDC

Guidance in this document is up to date as of September 20th, 2023.

Appendix 8: Signage

Guidance in this document is up to date as of September 20th, 2023.

Droplet Precautions

VISITORS: **Please speak with nurse prior to entering room**

PROVIDERS & STAFF
Clean Hands Prior To Entering And Upon Leaving

PROVIDERS & STAFF
Wear A Surgical Mask

Surgical Mask

PROVIDERS & STAFF
Wear Eye Protection

*Wear eye protection for potential exposure

PROVIDERS & STAFF
Use Dedicated or Disposable Equipment

Guidance in this document is up to date as of September 20th, 2023.

Contact Precautions

VISITORS: **Please speak with nurse prior to entering room**

EVERYONE
Clean hands prior to entering

NECESSARY PPE
Gown and gloves

PROVIDERS & STAFF
Use dedicated or disposable equipment

EVERYONE
Clean hands upon leaving

PROVIDERS & STAFF
Discard gloves and gown before room exit

PROVIDERS & STAFF
Do not wear the same gown and gloves for the care of more than one person

PROVIDERS & STAFF
Clean and disinfect reusable equipment before use on another person

Guidance in this document is up to date as of September 20th, 2023.

STOP

Aerosol-Generating Procedure (AGP) in Progress

AGP Start Time:

_____

AGP End Time:

_____

Entry Time:

(AGP End Time + Delayed Entry Time)

_____

PPE

Guidance in this document is up to date as of September 20th, 2023.

Appendix 9: Isolation Checklist

Supply Checklist for Isolation Room or Area

Equipment	Stock Present
On PPE Cart:	
Eye Protection (face shield or goggles)	
Gloves	
Particulate respirators (N95 or equivalent)	
Medical (surgical or procedure) masks	
Gowns	
Available in or near the room/ area:	
Alcohol-based hand rub	
Plain soap (liquid, if possible, for washing hands in clean water)	
Clean single-use towels (e.g., paper towels)	
Sharps containers	
Appropriate detergent for environmental cleaning and disinfectant for disinfection of surfaces, instruments or equipment (Should be on the EPA List N)	
Large plastic bags in waste bins	
Appropriate biohazard bags	
Linen bags	

*Adapted from World Health Organization: Infection Prevention and Control of Epidemic- and Pandemic-Prone Acute Respiratory Infections in Health Care